MEMORANDUM FOR: Distribution

SUBJECT: Inter-Agency Meeting

TYPE OF MEETING	National Drug Policy Board Meeting *
DATE	~~26 July 1988~~ 27 Jul
TIME	~~1000 hours~~ 30m
PLACE	Roosevelt Room
CHAIRED BY	Attorney General Meese (This will be Mr. Meese's last mtg)
ATTENDEE(S) (probable)	Principals only
SUBJECT/AGENDA	Not presently known
PAPERS EXPECTED	Within a day or two
INFO RECEIVED	1200 hours, 13 July (Jeannette, 633-3435)

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~~SECRET~~

Attached is the agenda for today's Drug Policy Board meeting, as well as the minutes from the last meeting of 23 June. Today's meeting is primarily intended as a farewell to Attorney General Meese since this will be his last attendance at a National Drug Policy Board meeting. Although some substantive issues may be discussed at the meeting, none will concern Intelligence Community equities--all of the expected issues for discussion will involve domestic programs.

STAT

Larry

27 July 88

Date

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DRAFT

PROPOSED AGENDA
NATIONAL DRUG POLICY BOARD
WEDNESDAY, JULY 27, 1988
3:00 P.M., ROOSEVELT ROOM
THE WHITE HOUSE

I. Opening Remarks (Vice Chairman)

II. Legislative Initiatives Update (Dr. Donald I. Macdonald and Mr. Francis A. Keating II)

III. Public Health Service Proposal on Treatment (Vice Chairman)

IV. Office of Workplace Initiatives (Vice Chairman)

V. Domestic Eradication Plan (Mr. Francis A. Keating and Mr. John C. Lawn)

VI. DOD Role (Mr. Francis A. Keating)

VII. DOD Authorization Bill (Mr. Francis A. Keating)

- Lead Role of DOD in Detection
- Report to the Congress on Cost

VIII. President Commission on AIDS Report (Dr. Donald I. Macdonald)

- Recommendations Concerning Drug Treatment

IX. Chemical Industry Issues (Mr. Francis A. Keating)

- Eli Lilly - "Spike"
- Chevron - Paraquat

Meeting today at 3:00

DRAFT

NATIONAL DRUG POLICY BOARD
Summary of Meeting
June 23, 1988

I. Introductory Remarks. The Chairman convened the meeting at 10:00 A.M. The summary of the May 27th meeting was approved by the Board. Chairman Meese announced that there would be no Administration drug bill, but instead the Policy Board would submit a "checklist" of proposals to the Bi-Partisan Legislative Task Force for consideration.

II. Legislative Update. The Chairman introduced an Issue Paper containing priority items, identified by the Coordinating Groups, that fall within the six policy goals announced by the President in 1986. Mr. Meese then turned the floor over to the Coordinating Group Chairmen for discussion of their Group's proposals in the Issue Paper.

- Dr. Macdonald addressed items contained under goals 1-3 and 6 that had been developed by the Demand side. Dr. Macdonald circulated two handouts; one with proposed additions or substitutions to the Issue Paper, the other entitled "High-Risk Youth Initiative Elements."

- Frank Keating summarized the law enforcement initiatives that comprise goals 4 and 5.

Ms. Wrobleski voiced State Department's opposition to passport marking and advised the Chairman that all of the International initiatives would require new funding. The Board noted State's concern on the passport marking, however the proposal was approved.

Chairman Meese asked for, and received, the Board's approval of the Issue Paper and to recommend the President's approval of these measures. The Chairman asked the Executive Director to modify the Issue Paper to reflect the Board's amendments and to prepare briefing books based on the Issue Paper for use by the Executive Legislative Task Force negotiators.

III. Jack Lawn briefed the Board on the Domestic Cannabis Suppression Strategy and advised that during week of July 11th, the Chairman would publicly announce the strategy which has been named Operation Stop Crop. George Dunlop asked that the strategy reflect increased focus on the problem of marijuana cultivation on public lands, and proposed specific language for this change. Chairman Meese advised that the subject would be addressed in any of the

Administration's public statements concerning Operation Stop Crop. Chairman Meese directed Mr. Keating to meet with Messrs. Lawn and Dunlop to resolve any issues regarding cross designation of Forest Service personnel to investigate marijuana cultivation cases.

IV. Marion Blakey, Director of Public Affairs for the White House summarized the June 16th meeting of the Public Advocacy Working Group.

The meeting ended at 11:05 A.M.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D. C. 20201

JUL 6 1988

TO: The Chairman

FROM: The Vice Chairman

SUBJECT: Funds for the Office of Workplace Initiatives

ISSUE

The Office of Workplace Initiatives (OWI) was established within the National Institute on Drug Abuse, Department of Health and Human Services, in response to Executive Order 12564 of September 15, 1986, which included a mandate for a drug free Federal workplace. The subsequent Anti-Drug Abuse Act of 1986 did not specifically provide funds for this effort, but the Department made $3 million available to initiate the OWI from funds appropriated for prevention activities. Over $2.1 million of these funds, available for two years, was expended in 1987, leaving less than $.85 million for the current year. With these funds essentially exhausted, the issue now is continuance of the effort. Specifically, the issue presented is whether to seek reimbursement from other government agencies, not for the $3 million already expended, but for additional activities needed to continue the implementation of the anti-drug abuse initiatives specified by the President and the Congress.

DISCUSSION

At the same time as our original funding is running out, the role of OWI is expanding. A major change in the OWI program occurred in July 1987, nearly one year after the President's Executive Order, when the Congress passed the Supplemental Appropriations Act of 1987, Public Law 100-71. Section 503 of this law greatly expanded my role as the Secretary HHS and subsequently OWI overseeing the Federal Government's drug-free workplace program. The law requires the Secretary HHS to certify to the Congress that:

- each agency has developed a plan for achieving a drug free workplace in accordance with the President's Executive Order.
- comprehensive standards are established for all aspects of laboratory drug testing and laboratory procedures to be applied in carrying out the Executive Order.

- appropriate standards and procedures are established for periodic review of laboratories, and other criteria for certification and revocation of certification of laboratories to perform drug testing in carrying out the Executive Order.

- all agency drug testing programs and plans comply with applicable provisions of the law.

I was also directed to report to the Congress a detailed, agency-by-agency analysis of:

- the criteria and procedures to be applied in designating employees or positions for drug testing.

- the position titles designated for random drug testing.

- the nature, frequency, and type of drug testing proposed to be included.

No additional funding or FTEs were provided by the Supplemental Bill for this effort.

While some of the responsibilities have been accomplished, many tasks remain uncompleted. Even more important, the initial phase of implementation is critical to the long-term success of the President's Drug Free Workplace Initiative. Close oversight by HHS in the early stages of the program can ensure that the complex process of implementation across all agencies of the Federal Government is conducted in a manner which makes the President's goal a reality, while protecting the privacy and human dignity of all employees. This truly is a lasting legacy the Reagan Administration can leave to the Nation.

During the several negotiating sesions with members of the Congress which preceded passage of P.L. 100-71, Jim Miller, Director, OMB, assured me that my Department would not have to absorb the costs of this program for other agencies. The situation is critical, and absent a contribution of funds from the affected Federal agencies we will have to make substantial reductions and delays in our efforts to implement the anti-drug program.

We are asking for reimbursement in the amount of $1 million for OWI expenditures in 1988. This represents only 20 percent of the total that will have been expended on the workplace initiative by the end of this fiscal year. We believe these costs should be distributed to the various agencies based on their intended participation in the program.

The Department has many essential activities remaining:

- The Department of Justice has requested that HHS review the drug-free workplace plans of the Tier II agencies for compliance with the Mandatory Guidelines for Federal Workplace Drug Testing Programs;

- Tier III agencies must develop plans to implement the Federal drug-free workplace initiative and require technical assistance (an initial technical assistance conference was held on May 9-11, 1988);

- Additional staff time and consultant costs are anticipated in response to expected legal challenges.

There will be a continuing, similar requirement for 1989, but at a higher dollar level. The only alternative for FY 1989 would be to request an amendment to the HHS budget.

RECOMMENDATION

I recommend that this issue be placed on the agenda of the next meeting of the National Drug Policy Board and that you support my efforts to obtain funds for this critical function.

Otis R. Bowen M.D.

Otis R. Bowen, M.D.

DOD MISSION STATEMENT

The Department of Defense, as the single lead agency of the Federal government for detection and monitoring in support of the National Drug Policy Board's interdiction strategy, will develop, integrate and coordinate a multiagency surveillance plan and implementing system to detect and monitor aircraft and vessels suspected of attempting to introduce illegal drugs into the United States. The Secretary of Defense will integrate the command, control, communication and technical intelligence assets of the United States that are dedicated to the interdiction of illegal drugs into an effective communications network.

POSITION PAPER ON

STIMULATING LOCALLY MANAGED DRUG ABUSE TREATMENT FACILITIES

BACKGROUND

There is the great demand for illicit intravenous drugs. In order to decrease demand, the national strategy requires an increase in prevention/education activities, an expansion of existing treatment modalities and the development of community based comprehensive drug abuse treatment programs.

The DHHS has the opportunity to demonstrate to the Nation that it can accept and fulfill a leadership role in the demand reduction activities associated with the war on drugs. The United States Public Health Service Commissioned Corps, and its civilian PHS counterparts, can provide the critical professional staff leadership and financial support to assist local and state authorities, and private not-for-profit organizations, to rapidly expand the size and number of drug abuse treatment programs to accommodate the need for such facilities.

Current Federal Government estimates are that less than one quarter of drug abusers have access to treatment programs. The National Institute on Drug Abuse (NIDA) estimates that the number of regular heroin addicts is between 400,000 - 600,000. The PHS Coolfont report, in 1986, estimated that the total number of regular intravenous drug abusers was 750,000. The National Association of State Alcohol and Drug Abuse Directors (NASADAP) 1988 survey indicates that New York, California and Texas report

260,000, 220,000, and 159,264 intravenous drug abusers, respectively, within their States.

NASADAP also reports that while there were approximately 350,000 treatment episodes provided to drug abusers in 1986, only approximately 100,000 of these treatment episodes were for either heroin or other narcotic abuse.

The longer the time in treatment, regardless of the referral source (criminal justice system or voluntary admission), the better the treatment outcome. That is, less criminal behavior and less use of illicit drugs, during treatment and after termination from treatment. These conclusions are drawn from the NIDA funded Treatment Outcome Prospective Study (TOPS), a multi-year, multi-city study of approximately 11,000 drug abusers who entered treatment during 1979-1981. Followup rates of these clients exceeded 80 percent.

TOPS as well as other studies, have demonstrated that more positive treatment outcomes are associated with those who stay in treatment for longer periods of time. Clients referred from the criminal justice system (and under their supervision) remain in treatment longer than voluntary admissions and thus are exposed to more treatment. Based on this study, and others, criminal activity is substantially reduced for the criminal justice client during and after treatment. Therefore, drug abuse treatment may be a rational therapeutic and economic alternative crime control technique.

The average time in treatment is greater for methadone maintenance treatment programs (mean of 38.4 weeks, median of 28.3 weeks) than either residential treatment programs (mean of 21.3 weeks, median of 11.0 weeks) or drug free outpatient programs (mean of 14.6 weeks, and median of 7.9 weeks). Approximately one-third of clients in methadone maintenance programs remained in treatment more than 1 year. Very few clients are referred from the Treatment Alternatives for Street Crime (TASC) diversion programs to methadone maintenance programs.

Recidivism to drug use, and especially a return to treatment, is not treatment failure. Drug abuse is a chronic recurrent disease with periodic exacerbations. Treatment provides the opportunity to foreshorten the course of these exacerbations and is useful in minimizing the associated morbidity and mortality.

APPROACH TO ENHANCING THE DEMAND REDUCTION EFFORTS

The DHHS has supported prevention, education, treatment and research activities in the areas of substance abuse (alcohol and drug abuse). States and local communities have been provided resources to develop interventions which are consistent with the needs of their ethnic and social communities. Counseling and treatment programs have been linked to community service programs to provide for continuity-of-care from entrance into a substance abuse treatment program to re-integration into the mainstream of society.

A joint effort, formally creating a partnership between Federal

and non-Federal personnel, facilities, and financial resources can provide the basis for a more aggressive effort to increase enrollment of drug users into the drug abuse treatment system. Existing Federal facilities (including military facilities identified for closure or having large unused capacity*) may be made available to local and State authorities, for rapid conversion to drug abuse treatment facilities. There is the opportunity to expand drug abuse treatment programs in former Public Health Hospitals. There is strong precedent for the transfer of Federal facilities to communities for their continued use as health facilities.

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There are other Federal and non-federal facilities which were designed to be operated as health care facilities, but which are currently being under-utilized for that purpose, for instance, the "old" Naval Hospital in San Diego, the Army hospital in San Francisco, and the numerous State and local tuberculosis sanitaria and mental health hospitals located throughout the country. Other possible candidates include the Naval Hospital in Philadelphia and the Fitzsimmons Army Hospital in Denver.

Implementation of these activities would commence with a rapid needs and resources assessment, by the United States Public Health Service, in conjunction with State and local authorities, in those communities which have nationally recognized high rates of intravenous substance abuse facilities in the major coastal waterways of the Nation. Those cities and States that wished to participate in such an activity could identify:

a) personnel to assume leadership roles;

b) facilities (under-utilized medical or community facilities) that might be expanded or renovated and placed into operation; and

c) funding resources which could be complemented or supplemented by the U.S. Public Health Service.

Preference for participation in this activity would be given those cities and States willing to make extensive use of existing diversion programs, for drug abusers, such as:

a) the Treatment Alternative to Street Crime (TSC) model, or

b) drug abuse treatment as a condition to probation or parole.

This action plan would include an effort and cost analysis that would ensure that any health care facility placed in operation, in a timely manner, met the appropriate life-safety code regulations. Staffing patterns could be developed concurrently. The staffing patterns for such facilities would be based on a review of known effective and efficient drug abuse treatment programs in the regions to be served.

Special efforts will be needed to identify appropriate and unique resources for the patient populations to be served. Not all substance abusers are the same. Many of the prospective patients will be in withdrawal, and alcohol withdrawal for example is different from benzodiazepine, cocaine or heroine withdrawal. Many of the prospective patients will have concurrent medical, legal, social and economic problems. Resources, when needed, and

when appropriate, must be available, if treatment, and thus the national demand reduction program, is to be effective.

The mixture of drug abuse treatment services include methadone maintenance and detoxification programs, outpatient drug-free treatment programs and residential treatment programs. Methadone maintenance and detoxification programs have been successfully operated as outpatient facilities. However, continuity of care, when methadone patients require inpatient hospitalization for concurrent medical or psychiatric disorders, requires that these patients be able to continue to receive their methadone medication, even when they are physically unable to regularly attend their outpatient treatment program.

Thus, the design and implementation of a drug abuse treatment program, integrated into the existent local health care delivery system can be facilitated by the use of active duty and ready reserve commissioned officers of the United States Public Health Service, and where appropriate, reservists, in medical and support billets, from the other uniformed services. Short-term consultations and longer term assignments can be arranged. Additional expert and professional assistance can be obtained through special service contracts and ordering agreements. These assignments will be goal-directed technical assistance, with local and state personnel agreeing to accept responsibility for the total administration, management and service delivery of the drug abuse treatment programs and their support activities.

A centralized coordinating office, in the Surgeon General of the Public Health Service's Office, would ensure that the needs

assessment, facilities identification and review, personnel and resource allocations, and personnel assignments of appropriate Public Health Service personnel (including Corps officers and civil service compliment) were conducted in a timely manner.

This activity could demonstrate to the States, local governments and the public, that an investment in expanding drug abuse treatment facilities will reduce drug demand. The DHHS and this Administration would be providing national leadership and would be the catalyst for other groups to further expand treatment facilities and treatment capacity.

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